

THE EXAMINATION OF ASSUMPTIONS IN CLINICAL NURSING
PRACTICE

DEBBIE BATE

Department of Graduate and Undergraduate
Studies in Education

Submitted in partial fulfillment of
the requirements for the degree of
Master of Education

Faculty of Education, Brock University

St. Catharines, Ontario

© December , 1994

ABSTRACT

This was a study designed to identify and explore the assumptions that Registered Nurses have about their current nursing role and practice.

A qualitative case study approach was used to gather descriptive data. Thirteen study participants completed the indicators of critical thinking exercise and participated in a group session in which they identified positive and negative critical incidents in their clinical practice.

The analysis of the anecdotes that were generated from the critical incident exercises revealed ten assumptions held by the Registered Nurses about their nursing practice. The ten assumptions were reflected back to the study participants to determine their level of agreement with each assumption. The ten assumptions were supported by the majority of the respondents.

The Registered Nurses in this study appraised themselves affirmatively on eight out of nine indicators of critical thinking.

ACKNOWLEDGEMENTS

I would like to acknowledge my thanks for the guidance and feedback afforded to me by my research committee members:

Patricia Cranton, Susan Wilcox, and Glen Jones.

I would also like to thank the nursing staff at Humber Memorial Hospital who willingly gave of their time to participate in this study.

Finally, I would like to thank my husband, Terry and my parents for their continued support and encouragement throughout this endeavor.

TABLE OF CONTENTS

Abstract.....	ii
Acknowledgements.....	iii
Chapter 1: Problem and Purpose.....	1
Chapter 2: Literature Review.....	8
Chapter 3: Research Methodology.....	27
Chapter 4: Results and Discussion.....	53
Chapter 5: Summary, Conclusions, and Recommendations ..	89
References.....	96
Appendix A: Letter recruiting volunteers.....	100
Appendix B: Indicators of Critical Thinking Exercise..	101
Appendix C: Critical Incident Questionnaire.....	103
Appendix D: Consent Form.....	104
Appendix E: Assumptions Exercise	105
Appendix F: Indicators of Critical Thinking Result Summary.....	109
Appendix G: Assumption Exercise Result Summary.....	110

CHAPTER ONE: INTRODUCTION

This was a study designed to identify and explore the assumptions that Registered Nurses have about their current clinical role and practice.

Assumptions are the beliefs that underlie our thoughts and actions. Brookfield (1987), a noted adult educator, identified that being aware that one holds assumptions and then reflecting on those assumptions are essential steps in the critical thinking process.

Nurses need to think clearly and objectively in their everyday clinical practice. They need to be able to identify all options and to continuously adapt their practice to meet new challenges. There needs to be ongoing self-questioning and self-appraisal. Why am I doing this, and could there be a better way?

The literature supports the importance and need for nurses to think critically about their clinical practice (Brooks, 1990; Miller, 1992; Schank, 1990; Street, 1992; White, 1990).

Critical thinking ensures that nurses' actions and decisions adapt to meet the demands of a changing health care environment. Although change is not a new concept in the field of health care, the type and

degree of change that is now being experienced is unprecedented in its scope and impact.

Statement of the Problem Situation

Nurses comprise the largest number of health care professionals working in acute care hospitals today. Although the traditional goal of nursing care, that of maximizing and promoting patients' health, has remained constant, the environment in which nursing is practised has been changing. Nursing practice has been, and continues to be, influenced by changes in the nurse-patient relationship, changes in technology and by the financial constraints affecting the institutions in which nurses work. It is essential that nurses reflect on their assumptions to ensure that these assumptions are congruent with the current goals and direction of health care.

Purpose of this Study

The purpose of this study was to explore the underlying assumptions that Registered Nurses, who work in an acute care setting, have about their nursing role and practice. This study used a qualitative approach.

Research Questions

The following questions were explored:

1. What are the underlying assumptions that Registered Nurses hold about their current nursing practice?
2. Do Registered Nurses reflect on the assumptions that influence their clinical practice?
3. Does the participation in the identification of critical incidents exercise promote the development of critical thinking in nursing?
4. How do Registered Nurses evaluate themselves on the indicators of critical thinking self assessment exercise?

Importance of the Study

It is important to investigate the assumptions that Registered Nurses hold about their nursing practice to determine if there is a fit between how nurses view their existing roles and the current and future directions in health care.

Without the capacity to identify and scrutinize the taken-for-granted assumptions that shape our practice, and without the ability to take alternative perspectives on familiar ways of

thinking, we are liable to be locked into increasingly outmoded ways of working.

(Brookfield, 1993, p. 197)

In order to reflect on an assumption, one has to be aware that the assumption exists. Nursing practice based on invalid assumptions could easily lead to poor decisions or incorrect actions. In addition, nurses need to be aware of outdated ideas and practices or they, too, could befall the same fate.

The findings of this paper may serve to reaffirm to nurses that they are reflecting upon and adapting the assumptions that underlie their practice in response to changing demands and priorities or, alternatively, that there is a greater need to critically reflect on their practice.

Nursing educators are continually seeking strategies to promote or encourage critical thinking skills in nurses. This research investigated the effectiveness of the critical incident exercise as a strategy for promoting critical thinking skills in nurses.

Although there has been recognition of the importance of critical thinking in the literature,

there is a sparsity of research that has been conducted with practising nurses (Miller, 1992). This study was the first to explore the assumptions of Registered Nurses and, as a result, may provide a new framework or perspective on critical thinking in nursing practice.

Definition of Terms

1. Acute Care Hospital- a hospital in which there is medical or surgical treatment as opposed to strictly a rehabilitative, palliative, or chronic care focus.
2. Clinical practitioner- a registered nurse whose primary job focus is the provision of bedside nursing care.
3. Critical thinking- a mental process involving reflection and appraisal when one examines the validity of the assumptions underlying one's actions and behaviours, and reflects on alternate perspectives and possibilities.
4. Registered Nurse- a nurse who has obtained either a diploma or a degree that enables her to practise as a Registered Nurse.

Assumptions

1. The ability to think critically is a desirable attribute for adults.
2. Adults have the capacity to think critically, but they also have the right to choose not to think critically.
3. The identification of assumptions is an integral component of critical thinking.

Outline of Subsequent Chapters

Chapter Two acquaints the reader with a review of the literature in critical thinking. The review will include an overview of critical thinking, variables that influence assumptions in nursing practice, and nursing research in critical thinking.

Chapter Three presents the methodology of the study. This will include discussion of research design, samples, data and information collecting procedures and recording, instrumentation and method of data analysis. Study limitations will be identified and discussed.

Chapter Four contains the study results and interpretations from the methods used: the Indicators

of Critical Thinking Self Assessment Exercise, the Critical Incident Exercise, and the follow up Assumptions Exercise. Chapter Five contains the study summary and study recommendations.

CHAPTER TWO:LITERATURE REVIEW

Introduction

The first section of this literature review contains an introduction to the concept of critical thinking. The role of reflection, and the idea of choice as an integral component in critical thinking will also be addressed. The second section of the review focuses on critical thinking in nursing with a look at the reflective practitioner and the variety of factors that may act to influence a nurse's assumptions about her practice. The review will conclude with the recent nursing research in this area.

Defining Critical Thinking

Critical thinking as an educational ideal is based on the philosophy that critical thinking is essential to true autonomy in our society. (Candy, 1991; Jones, 1992). Although there has been agreement in principle on the desirability of critical thinking, critical thinking continues to suffer from great ambiguity of meaning, due in part to the significant number of definitions that have been generated. Definitions of critical thinking have been developed by Arons (1985);

Bandman (cited in White, 1990), Beyer (cited in Klaassens, 1988), Brookfield (1987), Case (1994), debono (cited in Klaassens, 1988), Ennis (1985), Jones (1991) Langsdorf (cited in Mezirow, 1990), Mezirow (1990), Watson and Glaser (cited in Miller, 1992). This investigator has chosen the view of the critical thinker as developed by Brookfield (1987). Brookfield (1987) proposed that critical thinking is a process and that critical thinking skills develop over time.

Being a critical thinker involves more than cognitive arguments such as logical reasoning or scrutinizing arguments for assertions unsupported by empirical evidence. Thinking critically involves our recognizing the assumptions underlying our beliefs and behaviours. It means we can give justifications for our ideas and our actions. Most important, perhaps, it means we try to judge the rationality of these justifications. (Brookfield, 1987, p. 13).

This definition was selected by this investigator as it emphasizes the importance of recognizing one's assumptions (underlying beliefs), justifying them and determining if one's assumptions are still valid.

Brookfield's definition goes beyond a simple logical problem-solving strategy and includes the examination of one's self and one's assumptions. Mezirow (1991) used the term critical reflection to refer to this process of closely examining one's thoughts and beliefs.

The Role Of Reflection

To become aware of one's assumptions it is necessary that one reflect upon one's thoughts and actions. Many theorists support that reflection is an integral component of critical thinking (Harbison, 1991, Jones, 1991, Mezirow, 1991, Powell, 1989).

Dewey identified that reflective thinking requires suspending judgement, maintaining a healthy scepticism and exercising an open mind (cited in Mezirow, 1990). Mezirow (1990) further linked the two ideas in his definition of critical reflection "critical reflection refers to challenging the validity of presuppositions (assumptions) in prior learning" (p. 12).

Choice as a Integral Component of Critical Thinking

There is an assumption that most individuals are capable of critical thinking. It is important to acknowledge that people are not always able to think

critically in all situations. In addition, we must recognize thinking critically is a matter of personal choice.

Brookfield (1987) addressed the issue of consent and suggested that attempting to coerce someone into thinking critically may only serve to intimidate him/her or build up resistance to the idea of critical thinking.

Linked to the idea of consent is the idea of control. A term that is often used today is empowerment. Empowerment involves giving people the responsibility and the power to invoke change. Asking individuals to think critically and then leaving them powerless to change their behaviours or environment will quickly lead to the cessation of critical thinking. A "what's the use" attitude may prevail. A pattern of thinking known as learned helplessness may result. Learned helplessness is the giving up reaction, the quitting response that follows from the belief that whatever you do, does not matter (Seligman, 1990).

Sternberg (as cited in Norris, 1985, p. 44) expressed the viewpoint that no matter what level of

critical thinking skill a person possesses, it will be of no practical benefit unless the person is disposed to use those skills when he/she needs to. Norris (1985) elaborated on this idea and identified that having a disposition to use critical skills is analogous to having a "critical spirit."

The critical spirit requires one to think critically about all aspects of life, to think critically about one's own thinking, and to act on the basis of what one has considered when using critical thinking skills (Norris, 1985, p. 44).

Questioning and reflecting on one's assumptions is unsettling and many individuals may choose not to do so. It is extremely difficult for an individual to acknowledge that assumptions that have long been held may no longer be appropriate. Mezirow (1991) suggested that this knowledge could result in a significant blow to the self-concept.

Learner readiness is also an issue. Brookfield (1987) suggested that there often needs to be a catalyst, such as a major life event, before an individual will choose to reexamine his/her assumptions and priorities.

Critical Thinking In Nursing

The reflective practitioner. The ability to reflect on what one knows in a given situation is essential to an expert's clinical practice. By reflecting on decisions, a nurse is able to take independent actions instead of engaging in rote responses or unquestioned adherence to policies and procedures. Critical thinking involves asking questions: asking not just what to do, but in addition, demanding to know the reason why.

Schon defined the reflective practitioner as:

One who constantly watches herself in action; discovers and acknowledges the limits of her expertise, attempts to extend this, and accepts the clients'/patients' rights to retain control in their lives and take part in decision making. She is professionally mature enough to reveal uncertainty, and accept the risks inherent in all decision making. (Schon, cited in Harbison, 1991, p. 404).

Practitioners may fail to reflect on the assumptions underlying their actions when their practice becomes routine (Powell, 1989). In addition,

when there are many changing variables there is an increased propensity to hold true to the assumptions that underlie much of one's practice. "But that's the way we've always done it" is a common expression that may be heard when current nursing practice is questioned.

Factors that may influence nurses' underlying assumptions. It would be overly simplistic to envision a nurse reflecting on his/her practice and implementing actions in isolation, without being affected by external factors.

People cannot reach adulthood without bringing with them assumptions based on their previous life experiences. Adult assumptions are affected by culture, geographic location, age and socio-economic factors (Brookfield, 1987).

In addition to these factors, the assumptions and actions of clinical practitioners are also influenced by variables such as the health care consumer, nursing education, peers, working environment, and economic climate.

Nursing education. No consensus exists about the

question of whether critical thinking is an innate ability or a system of learned or taught skills (Klaassens, 1988). "How to teach" and "what to teach" are topics evoking much discussion among nursing educators (Callahan, 1992, Klaassens, 1988, Schank, 1990, Synder, 1993, White, 1990).

Upon graduation, nursing students possess an extensive body of nursing knowledge. One assumption that may be held is that this information is above scrutiny. It is not uncommon to hear "Well; that's the way I was taught in nursing school" as the closing remark to an argument. Mezirow, (1991) suggested that "perhaps even more central to adult learning . . . is the process of reflecting back on prior learning to determine whether what we have learned is justified under present circumstance" (p. 5).

Nurses must be aware that their initial academic preparation is not sufficient. Continuing education is essential. The generation of new information is constant. Information that was valid yesterday may be erroneous today. Nurses need to be educated not only to function in the now, but they also need the skills to function in the future.

It is increasingly important that nurses master the thinking and reasoning skills needed to process and evaluate both previously acquired and new information. Synder (1993) noted that practising nurses who lack these skills will find themselves in "untenable positions." Educators are responsible for the facilitation of nursing continuing education in hospital settings. Educators are in a position to promote and foster critical reflection of nursing practice. However, in many organizations the emphasis of in-house staff development is on hospital orientation and policy/procedural knowledge. This focus, although important, does not provide clinicians with the opportunity to develop a full range of critical thinking skills (Synder, 1993).

Peer support and the working environment. Critical thinking in the workplace avoids stagnation and atrophy caused by accepting unchallenged assumptions from the past (Brookfield, 1993). Thinking and speaking critically about hospital practice involves considerable risk.

Nurses have identified that becoming critically

reflective in a hostile culture puts them at risk for "cultural suicide." They may experience such adverse effects as becoming personally disliked, suffering career set backs, losing their friends, and becoming institutional pariahs (Brookfield, 1993).

Peer support for new and innovative ideas is not always present as many nurses may resent the critical thinker for disturbing the status quo.

Street (1992), a sociologist, presented the argument that nurses are not unaware of how they are failing to support each other:

Clinical nurses are not cultural dopes. They are aware of many of the ways in which they are oppressed, and in many instances they are aware of the ways in which they are implicated in their own oppression and in their oppression of others.

(Street, 1992, p. 11)

Case (1994) argued for the importance of collaboration among nurses. Perry (cited in Street, 1992) noted that it is important to acknowledge that nurses are part of a system, and that critical thinking can be supported or suppressed by that system.

Economic Considerations

There is a current trend in health care toward productivity and cost containment. Synder (1993) suggested that this trend measures a nurse's success against the number of allocated tasks completed within a prescribed period. A task focus is efficient, but it remains questionable if it addresses what the consumer deems important.

Historically there have been cycles of increases and decreases in the availability of nursing positions. For the first time large numbers of nurses are being affected by hospital down sizing. In the past, an employed nurse was usually secure in her position; job security is no longer a guarantee.

There has been a rallying call to nurses to mobilize their energies rather than passively await their unknown future (Buzath, Lievaart, & Schow 1992, Glass, & Dick, 1992). Nurses need to critically examine their options and adapt their practice to reflect consumer needs.

Role of the Patients (Health Care Consumers)

There has been a move in health care from viewing

the patient as a passive recipient of care to seeing the patient as an individual who wants to take an active part in deciding what he/she needs and the type of care he/she will require. Patients are consumers of a product with which they expect to be involved. Viewing the patient as a customer is a relatively new concept. A previous assumption had been that the patient was fortunate to be receiving nursing and medical care. The focus now is that the hospital or institution is fortunate in being able to meet the customers' needs. Hospitals without customers do not need nurses.

It is predicted that in the future consumers will have significantly more information and power to choose among health care providers (Prescott, 1993). This change in consumer orientation requires nurses to adjust and redirect the focus of their care. In order to accommodate these changes, nursing staff may need to examine their professional and personal values and acquire new skills.

The nurse must learn to relinquish an authoritarian position and establish a more collaborative relationship with the patient. Street,

(1992) in her nursing ethnography, made note of the hegemony present in the physician nurse-relationship. It could be argued that historically a similar type of relationship has existed between nurses and patients.

Nursing has been described as being both an art and a science. The science component of nursing is considered to be the nursing actions that are concrete and measurable (e.g., technical skills). The art element of nursing includes such things as showing concern, consideration, patience, and friendliness (Megivern, 1992). Megivern, Halm, & Jones (1992) found that patients often identified the amount of caring demonstrated by the care provider to be of more importance than the technical quality of care received. Nurses, in many organizations are often rewarded for efficiency and technical/analytical skill, thus creating conflicting expectations between the components of care that are felt to be important by patients and the expectations of the organization.

Critical Thinking In Nursing: Research

With the growing recognition and acceptance of the

importance of thinking critically in nursing practice, there has been a great deal of research conducted in academic settings on promoting and measuring critical thinking skills (Bauwens & Gerhardt, 1987, Berger, 1984, Brigham, 1989, Brooks, 1990, Gross, Takazama & Rose, 1987, Kintgen-Andrews, 1991, Miller, 1992, Sullivan, 1987).

These studies involved either a longitudinal approach (measurement of critical thinking as students progressed through the program) or a comparison of students who were at different levels in the nursing program. The results of these studies have been inconclusive. Many of the studies have showed no significant gain in critical thinking skills. (Bauwens & Gerhardt, 1987, Brigham, 1989, Brooks, 1990, Kintgen-Andrews, 1991, Sullivan, 1987), while other studies identified significant gains (Gross, Takazawa, and Rose, 1987, Miller 1992).

Several authors have offered explanations for these diverse findings. Kintgen-Andrews (1991) summarized the major findings of the research that had been conducted with nursing students. In her summary, she suggested that critical thinking may be more

complex than the construct that is commonly measured.

Brigham (1989) postulated that either critical thinking skills do not increase as nursing students progress academically or that the Watson Glaser Critical Thinking Appraisal Scale does not measure the critical thinking skills used by nurses.

This latter point that was identified by Brigham brings up an interesting concern or question about the Watson Glaser Critical Thinking Appraisal Scale (WGCTA). This instrument is frequently used to measure general critical thinking abilities (Brigham, 1989, Brooks, 1990, Kintgen-Andrews, 1991, Miller, 1992). Although there has not been a consensus in the nursing literature on what constitutes critical thinking, there has been acceptance that the WGCTA measures it! The WGCTA is the most frequently used test of critical thinking. The scale was developed to provide a sample of the ability to think critically about statements encountered in daily work, magazines and newspapers (Kintgen-Andrews, 1991). It is questionable if critical thinking in these contexts would be transferable to a nursing clinical setting. Watson's validity and consistency have been well established,

but reliability becomes questionable when used in alternate settings.

Jones, & Brown (1992) completed a research study whose purpose was to characterize critical thinking as it is currently interpreted in nursing education programmes. The study was completed by the distribution of 470 surveys to nursing students enrolled in a baccalaureate program. The questionnaire was developed by the researcher and addressed such questions as content of program, and how the respondent envisioned critical thinking. Two hundred seventy five questionnaires were returned. Jones' findings revealed that the predominant model in baccalaureate nursing education in the United States is based on critical thinking as a problem-solving activity, using principles of objectivity, prediction and control.

There have only been three studies done that have investigated the critical thinking skills of clinical practitioners. Powell, (1989) a nursing educator, designed a study to investigate the use of reflection in action in the everyday work of Registered Nurses. A qualitative approach was used that combined participant observation and interviews. Her sample

consisted of eight practising nurses. Powell found that reflection was present extensively in the form of nurses' ability to describe and plan actions, but was present to a much lesser degree in the recognition of value judgements.

Powell (1989) stated that:

It is important for Registered Nurses to be able to learn from their everyday work and use the knowledge from nursing and other disciplines, rather than as is demonstrated here, separate theory from practice and be relatively unable to learn from work. (p.832)

Beeken (1993) compared self-concept and critical thinking in practising nurses in a wide range of clinical settings. The California Critical Thinking Skills Test and the Tennessee Self-Concept Scale were the instruments used. No statistically significant relationships were identified.

Street (1992), a sociologist, completed a critical ethnography of clinical nursing practice. She posed the question- how do nurses think, act and reflect on their clinical nursing practice? Her qualitative methodology included participant observation and

interviews. Street's anecdotes conveyed that nurses have powerful oral communication skills that allow them to convey their critical thinking skills and problem-solving abilities to each other, but that the nurses are often unable or unwilling to convey this knowledge in writing. This failure to communicate in writing leads to a reduction in power. Street gives numerous anecdotes about the hegemony that exists between nurses and physicians, and nurses and administrators. The author suggested that nurses continue to be oppressed because: They are unable to move from individualism to collaboration, they are unable to document their clinical knowledge and practice for reflection and critique, and they are unable to challenge the power base of the medical and administrative cultures articulated and perpetuated through means of written communication. (Street, 1992, p. 267)

Conclusion

This review of the literature has demonstrated that critical thinking is a complex and important concept, and that the factors that impinge upon one's

assumptions and one's ability to think critically are numerous and diverse.

Although there is not a consensus on all the issues that surround critical thinking, there is support for the continued research and investigation of critical thinking skills.

CHAPTER THREE:RESEARCH METHODOLOGY

This chapter will include a description of the research design, the sample population, the instrumentation, and data collection procedures.

The purpose of this study was to explore the underlying assumptions that Registered Nurses working in an acute care setting have about their role and practice.

Research Questions

The following questions were explored:

1. What are the underlying assumptions that Registered Nurses hold about their current nursing practice?
2. Do Registered Nurses reflect on the assumptions that influence their clinical practice?
3. Does the participation in the identification of critical incidents exercise promote the development of critical thinking in nursing?
4. How do Registered Nurses evaluate themselves on the indicators of critical thinking self assessment exercise?

Critical thinking is an elusive concept. There often is a human desire to quantify and measure with

the goal of increasing one's understanding of a phenomenon. In the past this need has been addressed by the quantitative research on critical thinking that has used measurement scales such as the Watson Critical Thinking Appraisal and the California Critical Thinking Skills Test.

It is the belief of this researcher that it is not possible to investigate underlying assumptions using traditional quantitative research methods. A qualitative approach must be considered.

Qualitative research emphasizes individuality, acknowledges situational variability, takes into account the apparently random nature of human affairs, and that above all gives due prominence to the fact that people are active choosers and participate actively in the creation of the social world of which they are part. (Candy, 1991, p. 438)

Qualitative researchers are interested in meaning, how people make sense of their lives, what they experience, how they interpret these experiences, and how people structure their worlds (Merriam, 1988).

Properties of qualitative research include:

1. Descriptive: the end product of the research is a rich, "thick" description of the phenomenon.
2. Heuristic: the research increases the reader's understanding of the phenomena under study.
3. Inductive: the concepts or ideas emerge from the examination of the data (Merriam, 1988).

In qualitative research the researcher has a much more involved role than is traditionally seen in a quantitative approach. The researcher is actually an instrument in the research process, and needs to be responsive to the context, able to adapt techniques to the circumstances, and be sensitive to nonverbal communication. The total context must be considered. The researcher should act as a conduit for information and strive not to change the essence of the information that he/she receives.

In addition, qualitative research demands that a researcher is open and honest about his/her biases, assumptions and theoretical orientation. Viewpoints are espoused throughout any thesis, but qualitative research demands more researcher disclosure to ensure that issues around internal validity and reliability

are addressed.

Instrumentation

Two exercises were used in this study to assist in the collection of data from the participants. The exercises included the critical incident exercise and the indicators of critical thinking self assessment exercise.

Identification of Critical Incidents Exercise

A critical incident is simply an individual's detailed description of a significant event in his or her life. The identification of critical incidents and the subsequent reflective examination of these incidents have been identified as an appropriate strategy to use in eliciting an individual's underlying assumptions (Brookfield, 1987, Cranton, 1992, Mezirow, 1990).

The use of the critical incident technique was first introduced by Flanagan (cited in Brookfield, 1990). It has been widely used in educational research (Killer, McKee, Wilson and Ressano cited in Brookfield, 1990). Brookfield argued that critical incidents produce "incontrovertible sources of data representing a learner's existential realities" (p. 180).

A critical incident is explored for the assumptions that underlie the individual's behaviours during the incident and his or her reactions to the incident, both at the time and in retrospect. The incident is also analyzed for common themes emerging from the experience. The themes are then examined with the goal of determining underlying assumptions. These assumptions or beliefs are reflected back to the individual for validation. As a way of encouraging critical reflection, individuals can, and are asked to, analyze the incident as to the assumptions underlying their behaviours, the sources of those assumptions, and the consequences of acting on those assumptions (Cranton 1992, p. 160).

This technique is rooted in the phenomenological research tradition and presumes that learners' general assumptions are imbedded in, and can be inferred from, their specific descriptions of particular events (Brookfield 1990). As with all phenomenological approaches, the purpose is to enter another's frame of reference so that structures of understanding and interpretive filters can be experienced and understood by the researcher as closely as possible as they are

experienced by the learner (Candy, 1991).

The advantage of critical incident exercises in eliciting respondents' assumptions is that, as in critical questioning, the emphasis is on specific situations, events, and people. Instead of being asked to write about abstract concepts, respondents concentrate on describing particular happenings. These are generally much easier to report on than are broad statements or underlying assumptions (Brookfield, 1987)

An ethical concern that is highlighted when using this technique is that the researcher should be prepared for emotional responses. It is discomfoting to consider the possibility that one has been operating under invalid or distorted assumptions. The researcher must act with care and sensitivity (Brookfield, 1990).

Indicators of Critical Thinking Self Assessment

Exercise (Appendix B)

This exercise was designed to allow nurses to evaluate themselves on ten different statements. These statements were developed to reflect the indicators of critical thinking. The indicators of critical thinking as proposed by Brookfield are:

1. Contextual sensitivity: awareness of how context distorts assumptions;
2. Perspective taking: viewing the world from another's perspective (e.g., viewing both sides of a dispute);
3. Tolerance for ambiguity: allowing for multiple interpretations of complex problems;
4. Sceptical of standardized solutions to complex problems;
5. Seeking and exploring alternative ways or actions without there being a crisis;
6. Challenging group think (unchallenged theories, unquestioned practices, certain ideas that are accepted without question);
7. Avoiding premature ultimates: (ideas or concepts that when introduced stop any further discussion);
8. Future open to possibilities: change is fundamental to life.

The statements in the exercise were designed to allow self appraisal on all of the indicators, excluding indicator seven. Statements #1, #2, #3, #4, #5, #6, and #8 were based on indicators one, two, three, four, five, six and eight respectively.

Statement #7 was designed to focus more precisely on the indicator: challenging unquestioned practices. Statement #9 was designed to focus on the important component of reflection. Statement #10 involved identifying how much one's peers reflected on their actions.

It was anticipated that the exercise would have internal validity in that it would reflect the individual's perception of their own reality. This exercise was not designed as a tool of measurement but instead as an exploratory vehicle to determine how, or if, individuals appraised themselves on the indicators of critical thinking. A Likert scale was used as a means of assisting the researcher to cluster and organize the data gathered.

Validity

Internal validity is a measure of how one's findings match reality. Qualitative studies usually have high internal validity (Merriam, 1988).

Merriam (1988, p.169) suggested six strategies that can be implemented to ensure internal validity. Four of the six strategies were appropriate and

feasible for this study:

1. Triangulation includes using multiple investigators, multiple sources, or multiple methods to confirm the emerging findings. The critical incident exercise was conducted in a small group setting. This allowed for the interpretation of each participant's critical incident by the three or four members of the group. Group discussion increased the validity of the interpretations as opposed to the interpretations only being done by the investigator.

2. Member checks included taking data and interpretations back to the people from whom they were derived and asking them if the results were plausible. This was achieved in the critical incident exercise by having the participants immediately respond to other group members interpretations of their critical incidents. A second member check was done after the analysis of the anecdotes. The assumptions that had been derived from this analysis were given to the participants to provide them the opportunity to confirm or refute the assumptions.

3. Peer examination included asking colleagues to comment on the findings as they emerge. Fellow

educators and nursing peers were solicited to assist in this process, in addition valuable feedback was contributed by the research committee at the proposal and thesis level.

4. Identification of researcher biases involves clarifying the researchers assumptions, world view, and theoretical orientation at the onset of the study.

Reliability

Reliability refers to the extent to which one's findings can be replicated or repeated. Reliability is difficult to achieve as human behaviour is not static. Merriam (1988) preferred the use of the word dependable or consistent and identified strategies to ensure this:

1. The investigators' position: The investigator should explain the assumptions and the theory behind the study, his or her position in relation to the group being studied, and the basis for selecting informants.
2. Audit trail: The investigator must describe in detail how data were collected, how categories were derived, and how decisions were made throughout the inquiry.

As identified earlier both internal validity and

reliability demand researcher disclosure. For the following brief synopsis of this researcher's biases, assumptions and theoretical background the first person tense will be used.

I am a Registered Nurse currently employed in the position of nurse educator in an acute care hospital setting. I interact daily with the staff nurses who were participants in this study. The relationship is a collegial one in that there is no formal power or authority line between the educator and practitioner role.

Historically, I have expressed a preference for the quantitative research approach. It is only after much internal debate that I have come to recognize that although a quantitative approach (concrete measurement) provides me with answers, it does not necessarily supply the answers to the questions that I really want to know.

I believe that one's assumptions about nursing care and one's assumptions about the nurse-patient relationship are inseparable. Nursing is caring for patients. How this can best be achieved is the question.

If I had been asked if I was a critical thinker before embarking on this research, I would have confidently responded yes: both as a nurse and as an educator. This opinion changed when I appraised myself based on Brookfield's indicators of critical thinking. I found myself reluctantly acknowledging that I have a low tolerance for ambiguity and I became aware of my own voiced premature ultimates, such as "that's the way I was taught" and "that's the way it is in the policy." I reached the conclusion that I was not as open to new ideas, or as reflective of my own practices as I would like to be. If your practice or your life is based on faulty assumptions it narrows and constrains who you could be or what you could be doing. It is the easier road not to question one's self or one's practices, but you do a disfavour to yourself and to the recipients of your care or service when you do not. I think that many nurses do not reflect upon on the assumptions underlying their clinical practice.

I support Seligman's (1990) idea that "habits of thinking need not be forever" but one needs to be aware of one's behaviours or thinking patterns before they can be changed (pg. 8). Awareness and actual

change are not an automatic sequence of events, but there is increased power and control in at least knowing your assumptions. I also recognize that I have my assumptions about good or bad clinical practice and that one of the major challenges that I would experience in this research was to receive and reflect the data, without judging another individual's assumptions or perceptions.

External Validity

External validity is concerned with the extent that the findings of one study can be applied to other situations, and how generalizable are the results of a research study.

If a moment in time is unique, how can it be repeated? There is a debate if external validity can ever really exist with qualitative research. Merriam (1988) argued that the best one can realistically aspire to is to provide a description that will specify everything that a reader may need to know in order to understand the findings. Two strategies were used to achieve this goal. First a rich, thick description was provided so that anyone interested in transferability had a base of information appropriate to the judgement.

Second, the researcher described how typical the program, event or individual was, compared with others in the same class, so that users can make comparisons with their own situations. (Merriam, 1988)

Study Limitations

1. This research depended upon participants being willing to be involved in a 90 minute group session, there was some difficulty recruiting 14 participants.
2. Although there is not a formal authority line between this researcher and the nursing staff, the nursing staff members may have been reluctant to share their ideas or thoughts with an interviewer that they know.
3. The staff who were willing to be involved in this study may not have been representative of the larger body of nursing staff within the hospital.
4. The indicator of critical thinking exercise had not previously been used for this subject of investigation.

Each of these limitations will be discussed in further detail.

Setting

The research was conducted at Humber Memorial Hospital a 270 bed acute care community hospital. Humber, like most other hospitals in southern Ontario, has been subjected to budgetary cutbacks. It is noteworthy that at this point in time there have been no cutbacks or lay offs of nursing staff.

Sample Selection

A purposeful sample was used. Only Registered Nurses who were currently employed at Humber Memorial Hospital were recruited. Registered Practical Nurses were not included in the sample as they have differing academic preparation and role responsibilities.

Eighteen nurses indicated willingness to participate; of this group, one staff member was ill on the day of the session and four others phoned before the session indicating that their work load did not permit them to leave the unit. All of the 13 participants who did attend were female. Twelve out of 13 were community college prepared. The years of working experience ranged from one to 15 years.

One study limitation pertained to the concern that the staff who were willing to be involved in this study may not be representative of the larger body of

nursing staff within the hospital. This limitation remains a valid one. When depending on volunteers one cannot control the group characteristics. The groups did contain Registered Nurses from a variety of clinical areas, who ranged in ages and years of experience. It is believed that this was a representative sample in that the vast majority of nursing staff, working in the hospital, are female and were educated in a community college setting.

Procedure

An electronic mail recruiting letter was sent out to approximately 350 Registered Nurses. Two nurses responded. Owing to this low response rate the investigator individually approached approximately 25 nursing staff. Staff were selected at random from different clinical areas and the only limiting factor was that the staff was working on one of the days of the scheduled sessions. Strict guidelines were devised for approaching staff; these included:

- 1) opening each discussion with the statement that the RN could decline to participate without any hesitation and without needing to specify a reason;
- 2) no mention

was made of the personal nature of the request; and 3) indecisive individuals were not influenced by the researcher in any way.

The format of the verbal request made it very easy for the RN to decline. It was essential that there was no coercion of the subjects.

Recruitment of nursing volunteers is often a challenging task. This potential difficulty in recruiting staff had been identified as a potential study limitation in the planning of this research. The most often cited reason for non participation was a lack of available time. Additional reasons included fatigue, feeling too negative, and a simple desire not to participate.

The staff who indicated a willingness to participate in the study were given the indicators of critical thinking self assessment exercise and the research consent form to complete prior to attending his/her scheduled session. The participant also was asked to review the instructions for the critical incident exercise so that he/she had an opportunity to think about and write down their selection of critical incidents before attending the session. It was

emphasized that the written anecdotes were for the participants reference only and would not be collected.

Small group sessions were scheduled. Each session was approximately 90 minutes in length, and four participants were signed up for each group. A total of five sessions were held with the actual group size ranging from two to three. In retrospect four participants would have been too many to have allowed for the identification of positive and negative anecdotes by all the participants in the 90 minute time interval. Even with the reduced group size the time did not always permit the length of discussion that some of the issues merited.

In the small group session, the indicators of critical thinking self assessment exercises were collected from participants but not discussed.

A group format was selected in preference to a one on one interview for the following reasons:

- 1) allowed for peer interaction;
- 2) allowed for multiple sources of feedback as opposed to a single interviewer;
- 3) created a more informal or relaxed setting than would have existed in an interview; and
- 4) allowed for this to be a group learning activity.

Case (1994) identified: "We can expand our own perspectives by getting inputs, sharing, and critiquing with others. Interpersonal exchange plays a vital role in critical thinking" (p. 103)

The groups were conducted in small meeting rooms. Food and beverage was provided to assist in creating a more informal atmosphere. The sessions were initiated by a welcome and a reiteration of the confidentiality of responses. I also reminded participants that each session would be tape recorded. The participants voiced no anxiety about the presence of tape recorder. Each session was tape recorded, but battery failure occurred once and narrative notes were jotted down immediately after the session. I believe that note taking during the sessions would have been distracting to the participants and also would have decreased the researchers ability to actively listen to all of the ideas and thoughts being expressed.

The exercise opening statement was as follows with some subtle variations:

In the session today I would like each of you to first identify a positive critical incident and then a negative critical incident. After you have

shared your anecdote each group member will have the opportunity to identify what they think you believe is important in your clinical practice. You do not have to be concerned about giving a wrong interpretation, as each speaker will have the immediate opportunity to identify if you are correct or incorrect in what you are suggesting.

The role of the researcher in the sessions was intended to be that of facilitator, the actual role was determined in large part by the autonomy and comfort level of each group. After each group member had presented their thoughts and ideas, I then posed questions, to the group, that were designed to elaborate or expand on ideas that had been presented by the group. I transcribed the tape recording of the first session before facilitating the second session. This proved to be an invaluable activity. Brookfield (1987) identified the importance of avoiding becoming fixed on one's own performance. I was able to recognize that I had at times been focusing more on my role than listening attentively. I also became aware of the need to step out of the traditional educator role. It was not expected or appropriate that I

provide solutions or answers to the concerns that were addressed. Having this awareness increased my effectiveness in the role of group facilitator for the remaining sessions. In addition, in the first group I had begun the critical incident exercise by identifying a critical incident of my own; I found that this took up additional time and did not add to the value of the session, I did not, therefore, include this in the remaining group sessions.

During the sessions, I asked the question exploring nurses' perceptions of people seeking health care. The question was positioned so that it naturally flowed after an incident involving a patient/nurse interaction. The question about the perceived value of this exercise for their peers was usually part of the session closing remarks.

At the onset, the groups were often quiet and vocalized feelings of uncertainty regarding the group activity. After the first positive critical incident was shared there was a notable increase in comfort levels.

One limitation that had been identified in this study was that although there was not a formal

authority line between this researcher and the nursing staff, the nursing staff members might have been reluctant to share their ideas or thoughts with an interviewer that they knew. I felt that this particular limitation did not come into play, and it could be argued that this potential limitation was actually a strength in this particular study. In my current role I have had the opportunity to establish a level of trust with many of the nursing staff, and I believed that if a level of trust had not been present the participants would have declined to participate. In addition participants mentioned at numerous intervals in the sessions that they felt free to speak frankly about certain issues knowing that their anonymity would be maintained.

Data Analysis

Critical incident exercise. The tape recorded or written data from each critical incident exercise was transcribed into a word processor.

Initial sorting of data was done using the Martin (Diekelmann, 1991) qualitative computer program. This program allows the user to select phrases from the

transcribed text and to create a one-line summary that captures the basic idea or theme of that phrase, the user then is able to cluster similar ideas or themes. At this first level of analysis there is minimal subjective interpretation, the aim is to objectively capture ideas or thoughts with no attempt to filter them. This activity has traditionally been done through the manual sorting of index cards. Final data analysis was completed by examining and resorting the clustered data with the goal of identifying and interpreting the significance or importance of the recurring themes or ideas.

The ideas or assumptions that were included in the written analysis were identified by multiple participants. For each anecdote selected there were numerous additional anecdotes that conveyed a similar intent or meaning. One of the most difficult tasks in the data analysis was the determination of which anecdotes/information would not be included in the written analysis.

Indicators of critical thinking self assessment exercise. The data from this exercise was analyzed by the examination of trends or patterns in how the

participants responded to each statement. The likert scale assisted in this process. Although both exercises were given to the same group of participants, there was no attempt to compare results, as although both exercises produced descriptive data, the critical incident focused on identification of assumptions and the indicators of critical thinking exercise focused on the self appraisal of specific critical thinking behaviours.

Assumptions Exercise In qualitative research the data interpretation is conducted by the researcher. A common concern is that the findings may solely reflect the researchers subjective interpretation and not the actual participants view points or beliefs. To address this concern a final "member check" was done. The check involved the participants completing another written exercise in which they were asked to identify their level of agreement on the ten assumptions that had been generated from the anecdote analysis. The data from the exercise was analyzed by the examination of patterns or trends in how the participants responded to each statement.

Ethical Issues

As with all research the issue of confidentiality was important. Participants were sharing thoughts and ideas and it was essential that their responses remained confidential. Confidentiality was ensured through the following steps:

1. No names were requested on the indicators of critical thinking exercise;
2. The written consent form stated that no names would appear on the written transcripts, reports, or published papers and that the participant was free not to answer any questions in order to protect privacy;
3. A statement of confidentiality was issued verbally prior to the start of each group session;
4. Specific or unique situational details were omitted from the report if they could lead to the identification of the speaker;

It was not anticipated that this research would cause the participants mental or psychological harm, but because of the nature of qualitative research, the researcher cannot always anticipate the responses of the participants. This issue was addressed by:

1. The written consent form identified that the

participant could withdraw from the study at any time;
2. Investigator awareness of this issue and therefore being sensitive to this issue and supportive in the group sessions.

There were no ethical issues surrounding deception or withholding information as the participants were given full disclosure of the research purpose and method before participating in the study.

Formal steps that were taken to address ethical issues included obtaining permission from Brock University to conduct research on human subjects, gaining research approval from the research committee at Humber Memorial Hospital, and having each participant sign a consent form.

CHAPTER FOUR :RESULTS AND DISCUSSION

This chapter will specifically address the research questions and will identify and discuss the research findings generated from the critical incident exercise, the indicators of critical thinking exercise and the assumptions exercise.

Analysis of the Critical Incident Exercise Do Registered Nurses Reflect on the Assumptions that Influence Their Clinical Practice?

Brookfield (1987) identified that there are two activities that are central to critical thinking; 1) identifying and challenging assumptions and 2) imagining and exploring alternatives. It can be argued that these really are three separate activities; 1) identifying assumptions, 2) challenging assumptions and 3) imagining and exploring alternatives. This argument becomes important when responding to the question: Do nurses reflect on their assumptions? Identification of assumptions simply involves awareness and recall. The activity of challenging assumptions involves reflection. Reflection is the examination of the reasons for one's beliefs, primarily to guide action

and to reassess the effectiveness of current strategies and thinking patterns. (Mezirow, 1990)

In the group sessions the participants demonstrated the ability to identify their assumptions, but there were very few anecdotes describing the challenging of assumptions and the imagining of alternatives. The anecdote below reveals how one individual was aware of her beliefs and behaviours but appeared unable to take the next step towards challenging assumptions or imagining alternative responses:

Z: If everyone in a situation is equally to blame would you accept responsibility for the group?

A: I think I'd take the blame . . . even if I thought that they should get some of the blame, I'd still somehow feel it was my fault . . . that's me!

In the following anecdote one peer challenged the assumptions of another. Although there was no resolving discussion, there may have been further reflection on the incident by the participant.

M: The daughter asked me how would you want your mother treated? I really had to bite my tongue

from retorting that I certainly wouldn't have prolonged my mother's life through tube feeds!

K: Did the daughter make you feel defensive?

M: A little, but she made me more angry than anything.

K: Is it possible that you were judging the patient's quality of life by your own standards as opposed to what the family thought?

M: shrugged response.

One participant identified that the following critical incident had made her carefully examine her assumptions when attempting to explain a patient's behaviour, and that she had since really strove to keep an open mind (challenging assumptions).

H: And it turns out that she had a rare tumour in her hips that was very, very painful and I think that we were all devastated to think that we didn't believe her and that at a certain point we took on the attitude that this woman is psychotic. I gained some real awareness from that, not just to assume someone is, you know, putting on a bit of a play or game. It was an eye opener for me.

The following anecdotes reflect nurses' ability to gain insights from negative events:

E: Even though it was negative it turns out to be positive cause we learn from it . . . you know . .

The recognition of the importance of lifelong learning was conveyed in this anecdote.

D: I find we're always learning. I'm learning from past experiences, you seem to be picking up every time you do something. There are so many different problems so many different ways.

Does The Participation in the Critical Incidents Exercise Promote the Development of Critical Thinking in Nursing?

Registered Nurses are able to identify their beliefs (assumptions), but many engage in minimal reflection on those beliefs. The critical incident exercise gave the participants the opportunity to vocalize and share these beliefs. The peer sharing provided an opportunity to examine specific beliefs and/or prompted further self examination of those

beliefs.

It is often difficult to determine the effect or impact of an exercise. One of the clearest messages conveyed by the participants was the affirmative response to the question: "Do you think that this exercise would be beneficial for your peers?"

The participants identified that the activity gave opportunities to: 1) reflect on their actions and beliefs; 2) hear non judgemental opinions from peers; and 3) provide a forum for peer support and discussion.

C: I think it gets people thinking. It's not very often you can sit down with a group of people and talk about the same type of subject and then get some feedback. I mean there may be people out there who are thinking, hey maybe I need to change my ways a little bit. It's not until you hear it in a discussion. You're not likely to give feedback by saying I didn't like what you said to that patient, but if it's in a group session and people start airing their views . . . someone might go ah . . . maybe their thinking is better than mine.

D: It's helpful to share especially negative

experiences with each other. Others might gain some insight by what you say to them or what you interpret from what they are saying. Sometimes you don't realize what you're doing yourself until someone else points it out, and then a light comes on.

C: Taking the time out to pause and reflect is important and to identify that we really do have firm beliefs one way or another. People don't take the time to think about things.

What Are The Underlying Assumptions that Registered Nurses Hold About Their Current Nursing Practice?

Working on the premise that an individual's general assumptions can be inferred from their specific descriptions of particular events allows one to postulate assumptions surrounding clinical practice. An analysis of the critical incidents revealed a recurring thread of issues surrounding power and control.

Power is the exertion of control, influence or authority (Stein, 1978). Control is defined as to

exercise restraint or direction over (Stein, 1978)

Historically in nursing there has been an inequitable division of power and authority.

Nursing has traditionally been a female profession, and thus has suffered the many inequalities faced by women in the workforce at large . . . We have suffered lack of power in our health care institutions, little say in decision-making processes that affect our work environment, a heavy workload with few means to control it, a handmaiden, ministerial angel image, low professional status (particularly compared to doctors), and our own generally passive nature. (Smith,R. 1986 cited in Street, 1992, p.29)

Numerous critical incidents were articulated in which nurses vocalized feelings of frustration when they were involved in activities in which they did not control the sequence of events or plan of care. When the participants were asked if they had challenged or questioned the individual involved, their response was consistently "no" for all of the following anecdotes. This conveys an assumption in which nurses believe that they cannot control the actions of other people and

thus often take a passive stance. This lack of control leads to a great deal of frustration when it impedes or influences the delivery or outcome of care.

In the following anecdote the participant voiced her distress about the possibility of an alternate outcome.

K: He (the patient) was still talking when I arrived up on the floor . . . if he'd been transferred sooner . . . the outcome would have probably been the same (the patient died) but . . .

In the next anecdote frustration was generated at the inability to control a peer's actions during a crisis:

J: I was doing compressions for most of the code, and the nurse from ICU came over. This upsets me even talking about it, and started bagging and she wasn't following any routine. I was doing the 1,2,3, and she was just continuously bagging, and I knew the patient wasn't getting any air in. This made me very upset as it was throwing my routine off. It really did upset me . . . it disrupted the routine and when you're in a crisis

you really need a set routine to focus on . . . it was upsetting that she wasn't following it, I don't think that it would have changed the outcome of what happened (the patient died) but . . .

In the following anecdote one nurse articulated her awareness about her inability to control all aspects of her work environment.

C: I find it difficult balancing patient care and all the other things that need to be done within the position with a lack of ability to totally control my work environment.

This issue of lack of control was articulated in several of the negative critical incidents in which nurses made assessments of situations, but did not experience the expected support or follow up by physicians.

B: The patient wasn't doing well. We called the doctor and he didn't seem to take our concerns very seriously so we called the nurses over from the ICU to have a look . . . as soon as the ICU nurse got there and took a look at the patient she called the doctor . . . the doctor immediately

responded with numerous stat orders and directions . . . don't get me wrong I was glad the ICU nurse came over . . . I just resented that the doctor had listened to her and acted so quickly on what she said and hadn't really even listened to me . . . the ICU nurse wasn't the issue it was the doctor's response to her that was.

The following anecdote reveals an uneven balance of power in communication and in decision making between nurses and physicians.

In this incident a radiological procedure had accidentally been cancelled, ironically it was later determined that the mistake was the responsibility of the radiology department.

A: During the conversation with the doctor as I was trying to explain . . . he was saying:
"Nurses are always doing this! Nurses do this stuff all the time and I'm sick of it." I kept saying I'm sorry, I'm sorry.

Nurses often believe that it is their responsibility to deal with problems that are created

by others.

C: There are some doctors who are really difficult to work with and they can be so nasty to the patients. You feel, not that you have to cover up for them, but that you have to do or say something, as you don't want the patient to think that the doctor was really mad at them , or think that they were really a bad patient. Many of them (the patients) say "oh I was a bad patient wasn't I?". Which isn't true, sometime you have to reassure people when the doctors don't always, you know, treat them nicely.

The problem of fighting fires was identified when a nurse had to deal with problems and crisis created by other staff members.

D: You walk into the situation and everybody else has done the damage and there you are. You have to make things better so you're working three times as hard to get things organized. It always seems that negatives occur when other people have done the damage and you have to mend all the problems.

Patient-nurse interactions. In the past, health care providers assumed the role of decision maker. The current health care trend is to view people who access health care as customers or consumers who are partners in their care. (Bader,1988; Synder,1993).

The question was posed: Are people who seek health care patients or customers? The overwhelming response in this study was that people who seek health care in hospitals are patients needing to be cared for. This is an interesting example of the differences between what Brookfield (1987) calls theories in use and espoused theories. Espoused theories are the publicly agreed upon norms and practices that comprise appropriate professional practice, the theories people claim to follow, even when their own actions contradict this claim (Brookfield, 1987). Theories in use are the privately developed and proven ways of performing that practitioners believe in their hearts to be true (Brookfield, 1987).

The participant's responses reflect this dissonance between the awareness of the hospital's espoused theories and their own theories in use.

The following anecdotes convey this assumption

that patients are people to be cared for and nurtured and are not people who simply receive a service.

F: Good question . . . I still view them as patients . . . I'll be honest, and I'll never stop thinking of them as patients.

C: I don't know what they are any more to be honest . . . I know we deliver customer service . . . I think they are patients, I think that they are here because they are unwell . . . because they need nursing care or procedures done . . . to me they're still patients.

D: People who walk in the door are patients NOT customers..they come here to be nurtured. People don't want to be considered customers.

A: People admitted to hospital are patients, patients don't have a choice about being here. A customer is someone who can define and select what they want, patients don't have those choices available. I can see more how in the states they

have customers but their system is a lot different from the Canadian health care system.

E: They come here to be cared for and looked after. Patients who view themselves as customers have been influenced by outside sources . . . it's not something that they had initially felt themselves internally.

G: I think that there has to be a healthy respect for both, I mean sure they are customers and we want to make sure that they have a positive image of the hospital, but by the same token for me to help them I have to be able to do the things that I need to do as a care giver to help them on their way.

The idea of respect is an important one. One way that respect is demonstrated is through recognition and acknowledgement. The nurses in this study indicated that their job satisfaction was heavily influenced by the acknowledgement and appreciation that was received or not received from patients, families, and

management. The following anecdotes convey the assumption that many nurses believe that they need and deserve recognition for their efforts.

J: I guess for me it was the pats on the back that are almost non existent now, from family members. I don't know, I think with the changing times it has got to where you're expected to do this, they don't expect that you think that you should be thanked for your job. I'm just the type of person who says thanks to the grocery clerk when she's giving me back change. It's just something I do, when we get thanks from a patient or family member that's nice. It kind of makes your day.

There was a recognition of the multiple demands that impinge upon managers, but it was still felt that managers need to take the time to recognize and support staff in their care giving.

C: Well, I guess it's telling us we're doing our jobs whatever our expertise is, whatever we're doing on the floor, if we get thanks like that then we're doing a good job . . . no one ever says . . . gee that was well done . . . or your cohorts

or colleague, they never say much to you . . . and you don't get much appreciation from the nurse manager. It's very rare that they would say that a job was well done.

Patient's Expectations Of Care

Mutual respect may become the first victim in the power struggle that may exist between nurses and patients. Words may be exchanged without being understood and an adversarial relationship may develop. Nurses believe that they know best how to define and give patient care. Conflicts develop when the patient or family members believe they know best.

M: I felt good about the care that I'd given to the patient . . . and then the patient's daughter came in and immediately woke her up. The patient had just fallen asleep and then she (the daughter) began criticizing and questioning the care that I'd given her mother . . . like her position and . . . straightening out the sheets . . . I really felt angry and had to bite my tongue from saying something to her!

I: The patient said "I don't have to wash myself now . . . that's what you're here for dear! Because I pay for this you know" . . . My response was that we all do . . . pay for this.

Megivern (1992) defined patient satisfaction as the degree of congruency between a patient's expectations of ideal nursing care and the perception of the real nursing care he received.

E: The family comes in and they have this attitude like it's two o'clock my mum should be in bed . . . and there are only two or three of you on the floor and you are doing everything you can. You can't put everyone to bed at the same time!

Caring for patients takes enormous energy. " It's not easy to care for people - any people - any time - anywhere" (Kerr, 1991, p. 56). Sometimes nursing staff frustration is conveyed to the patients in a number of ways:

C: I mean the tone of voice says everything sometimes. People (patients) really pick up on that, they kind of pull back and go quiet and not

say anything anymore cause they don't want to bother you, but that's what we're there for, to look after these people!

D: Sometimes families and patients lose respect when they haven't been treated right by other people. Although you try, some staff don't care one way or the other. So maybe when they (the patients) come to you they sort of have a lower opinion.

Making Decisions

There exists a power struggle over who has the right to make decisions in the plan of care. This is not a new issue, but the balance of power is definitely changing as patients and families become more informed health care consumers. In the past paternalism has prevailed. Nurses still believe that health care providers (nurses and physicians) should possess the knowledge and authority to make decisions in the plan of care. Problems develop when patients or families refuse interventions that are perceived by the health care provider to be of value.

H: We're becoming more sue conscious or something. As there was a time when doctors . . . well maybe they did too much . . . they'd go the other way and do too much in any given situation, but somebody has to take control, I mean families are involved . . . emotions and everything. Somehow doctors have lost that autonomy or they are afraid to exercise it . . . and maybe nurses too . . . it's important that families are involved but . . .

G: Sometimes you need to take some of that control away, I really think there should be limits to what the patients and families can control . . . but I don't think that they should necessarily be given total or absolute control.

Giving Patients and Families Information

One way of decreasing potential conflict or disagreement is to increase the information that is shared with the patient and family. This information would include not only detailed information about their plan of care, but also would give a realistic portrayal of what they, the patient, can expect.

In the following situation the family did not want

any additional treatment for their mother and had refused the doctor's request for an xray.

G: Maybe a better explanation would have helped, like your mother is sick and she's in a lot of pain, and we really want to control the pain so we have to find out the cause and give us an idea into what is going on . . . and we can help her be more comfortable . . . I think sometimes if you put it in a certain way you might get a better response.

Nurses are expressing a feeling of uncertainty about how much information patients should receive, who the information should come from, and legal concerns about accidentally giving incorrect information or information that is misinterpreted.

C: We were taught not to say anything to the patient or offer advice . . . you just listened . . . that wasn't our position but now the role is changing . . . I can tell the patient information, but I still feel the physician needs to give information about the diagnosis and you have to have every word right as the patient will remember every word and will repeat to the doctor, the

nurse told me such and such. If any information is not right you have to be very careful.

Personal Caring

Personal involvement (e.g., friendship) with a patient can be a rewarding experience, the drawback is that tragedies also become personal and this can result in an emotionally draining experience for the nurse.

F: After the patient died, the daughter came in to thank me for everything I'd done, and all I kept thinking was the daughter was about 25, and her mother would never see her walk up the aisle when she got married . . . it was just very, very sad.

G: It was the patient's last hours and she was still conscious . . . she was very with it; I think if had dumped her in the emergency room I think she would have been hurt and I think her husband would have been hurt.

Peer support

Brookfield (1987) identified that peer support is

crucial to critical thinking. The following anecdote conveys the assumption that although it was important that nurses supported each other, peer support was not always present.

K: This activity (the critical incident exercise) allows opportunity for peer support and non threatening, nonjudgemental feedback. You may share your thoughts (in other settings), but people are judging you. Peers do judge and say things like "I wouldn't have done it that way." The implication being that they would have done it better and that your way was incorrect as opposed to giving support.

H: It's nice to see nurses supporting each other . . . it's not always that way. In fact, probably the contrary is more true we tend to be more antagonistic than supportive.

G: That female thing (brief laugh).

H: Yes! I 'm glad you said that. The cattiness thing, but it is nice to see nurses supporting each other.

The importance of having a supportive peer to

listen, was identified.

B: It's hard if you keep everything to yourself, you need some to people to talk with. Maybe sometimes when you see a situation it's more helpful when you get others views about it. It helps to cope with the stress of the situation. I found that really helpful.

Confidence in Own Clinical Skills

Strong clinical skills, assessments and knowledge base were identified as being important components of nursing practice that appeared to lead to increased self-confidence in one's nursing role. The assumption is that clinical competence allows one to feel good about one's nursing role. There is an increasing voice in nursing practice that is saying that caring alone is not enough, it must be supported by strong clinical practice (Kerr, 1991). Street (1992) discussed the idea of how there is power in clinical knowledge. The following anecdotes convey the positive feelings that the nurses experienced as a result of their clinical skills and interventions.

M: I went over to emergency and they hadn't been

able to start an IV on this unresponsive dehydrated infant . . . I attempted a scalp vein and was successful and the baby became hydrated and became responsive within a short period of time . . . it felt good.

D: The patient pulled his trach out, and I had to reinsert it and I'd never done that before. I did do it and it just went so smoothly and it felt good that I did it and it went very well. It was an extra skill that I've never been able to do anywhere else. It was interesting.

B: I was in with the patient much of the morning . . . talking to her, giving her emotional support, getting her to relax, and giving her non pharmacological methods of pain control ,using heat therapy warm towels for the pain in her legs and just talking her through it.

Team Work

The importance of teamwork, collaboration and common goals were identified. Respondents from one

clinical area were consistent in their identification of their effective team as being a positive motivating force that ensured that a nurse was not working in isolation.

A: Yes the group feels good - like a team winning or something - everyone played their part, you know- if they win the game that's great.

It's a positive thing . . . the nurses are together on it. It's not an isolated nurse doing one thing and not being followed up. I feel there is more follow up on what's been initiated on a given patient, more follow up type of thing.

Other respondents agreed with the concept of team but identified that for them it remained an area of growth.

J: I think there needs to be more team nursing . . . I think people are working together more, but I think that they have to do it as more of a team . . . not to have people being the hero doing it themselves . . . if there's no communication then things don't work.

Examples of respect and the enjoyment of working

as a team with doctors was also identified.

H: The doctor is doing a thorough work up on these patients and bringing them round like from practically a vegetative state to ambulation and getting them out of here.

Other Variables Affecting The Delivery Of Care

In the current health care climate there is a movement to doing more with less, both from a financial and staffing perspective. In addition, patients have shorter lengths of stay, and acuity levels have significantly increased. These changes sometimes present as challenging barriers to nurses in the delivery of care and frustration results when desired care outcomes cannot be reached.

C: It is becoming a lot more than it used to be in relation to frustration in your job. We're seeing more patients. We are doing a lot more types of things like starting Ivs, whatever, there's a lot more responsibility that goes with your job. I'm sure that the floors must find it frustrating as well . . . you have a lot more on your plate than

you used to have and the same staff and maybe even a little bit less sometimes.

Time is viewed as a valuable commodity, with the common theme being "there isn't enough time to care for patients" and appreciation was voiced when there was more time for doing the "extras."

B: It felt good. I felt that it was a positive critical incident for me at that point 'cause I was able to spend time with her, just running out sometimes to get things done, but I would always tell her where I was going and what I was going to be doing, and that I'd be back. Just being able to spend that time with her and talking her through it and seeing her feel better throughout the day. It felt sort of good spending the time with her.

J: It's nice that you are able to take the time to do that with patients; it's sort of like real nursing . . . you don't get a chance to do those little extras on the floor, even though you'd like to.

Summary of Findings from the Critical Incident

Exercise

The critical incident exercise allowed for the identification of numerous assumptions underlying nursing practice. The assumptions that are summarized below were extrapolated by the researcher from the critical incident anecdotes that were shared by the participants. The ideas supporting these assumptions were identified by the majority of the participants. It is not realistic and indeed diminishes the importance of the individuality of nurses to state that these assumptions are held by all nurses. This analysis does identify some of the important assumptions that nurses need to reflect on.

Summary of assumptions. Ten assumptions about nursing practice were generated from the analysis of the data.

Assumptions pertaining to patient care and interaction were as follows: 1) Patients are people to be cared for and nurtured and are not people who simply receive a service, 2) Nurses need and deserve recognition of their efforts, 3) Nurses know best how to define and give patient care, and 4) Health care

providers should have the knowledge and authority to make decisions about the plan of care.

The identification of these assumptions demonstrates that there is a disparity between the espoused view of the institution (person seeking health care is a customer who is an active partner in his/her care) and the theory in use of the nurses (person seeking health care is a patient who needs to be cared for). This disparity will increase as health care consumers demand more involvement in their care and as new legislation (Advocacy and Consent to Treatment) increases the rights of health care consumers. More open communication and information sharing is needed between nurse and patients, to ensure that expectations are realistic and that the needs of both groups are articulated. Patient satisfaction and nursing job satisfaction can be achieved through mutual recognition and realistic understanding of each other's changing roles.

Assumptions were identified relating to the inequitable power distribution in health care environments. 5) Nurses believe that they cannot control the actions of other people and 6) it is a

nurse's responsibility to deal with problems that are created by others. A point underlying both of these assumptions was that the nurses were unable to question or challenge peers or physicians who had caused them to experience frustration in their delivery of care. Nurses need to have the confidence to challenge or question the actions of other health care providers. It is recognized that this type of action requires strong inner resources, but continued avoidance of confrontation will sustain the frustration and diminish the practice of nursing.

The nurses in this study did identify the need and value of peer support and team work. The following assumptions were identified: 7) Peer support is important 8) Peer support is not always present, and 9) An effective team is a positive, motivating force that ensures that a nurse is not working in isolation. It is essential that nurses support each other, and recognize the value in team work.

The last assumption was that 10) Clinical competence allows one to feel good about one's nursing role. This assumption could be interpreted to summarize what is important to nurses : competent caring. It is

important to note that although there is a difference in how the patients role in care is envisioned by nurses and patients, both share the important common goal of maximizing patient health and functioning.

Indicators Of Critical Thinking Self Assessment

Exercise

Thirteen self assessment exercises were completed and returned. Statements #1 through #9 reflected the critical thinking indicators. Statement #10 was not an indicator statement, but was included to permit comparison between #9 and #10.

Two participants indicated that they had been unclear about the meaning of statement #1. In response this statement was reappraised and it was determined that the statement in #1 (I have firm convictions that don't change with circumstances) did not clearly reflect the critical thinking indicator: contextual sensitivity (aware of how context distorts assumptions). This statement was therefore not included in the analysis of the exercise results.

The self assessment exercises were reviewed by making "always true of me" the highest affirmative

response for Statements #2, #3, #5, #6, and #8. Statements #4, and #7 were reviewed with "never true of me" being the highest affirmative response. The number of participants responding to each statement is only identified to assist in a clearer description of the findings. A more detailed breakdown of participants responses can be found in Appendix E.

The majority of nurses responded affirmatively that were are able to view both sides of an argument (11/13), were able to seek and explore alternate ways of thinking (9/13), see many possibilities for the future (12/13) and reflect on the reasons for their actions (10/13)

The responses to #4. I believe that there is usually a simple answer to every problem, to #6. I question commonly held group beliefs, and to #3. I have a tolerance for ambiguity revealed a common response pattern. In each question there was a high level of "sometimes true" responses. The high "sometimes true" could be interpreted to reveal that these are behaviours that nurses recognize are important, but acknowledge that they are not consistent in initiating these behaviours.

In #3. and #4. and #6 if the "sometimes true" responses are combined with the affirmative responses a strong affirmative response is identified for each indicator (#3. 9/13, #4. 10/13, #6. 9/13).

In #7. I like to do things the way I've always done them, was the only indicator statement in which the majority of participants did not respond affirmatively. When one combines the "sometimes true" and the "often true" a negative response of (13/13) is revealed.

A comparison of the responses to Statements 9,10 revealed that 11/13 scored their peers lower than themselves when responding to the statements; I reflect on the reasons for my actions and my colleagues reflect on the reasons for their actions.

Brookfield (1987) suggested that when a participant is asked to identify a colleague's actions . . . the subjects are really talking about themselves, without being consciously aware of this. "When they criticize another's actions . . . they are saying something about their own conceptions of good practice." (p. 100).

Summary of Results of The Indicators of Critical
Thinking Exercise

The results generated from this exercise suggest that, with one exception, nurses do score themselves affirmatively on the indicators of critical thinking. Nurses are also able to honestly appraise that they do not engage in all behaviours consistently. The only indicator that generated a negative response (this statement was inversely scored) was the statement "I like to do things the way I've always done them". This statement had been based on the indicator of challenging unquestioned practices. The response to this statement is not surprising and should be evaluated in the light of the existing health care environment. In recent years the one thing that has remained consistent in hospitals is change. Changes in the areas of technology, care delivery and funding have significantly impacted on the delivery of care. The nursing response to this statement may not in actuality reflect a resistance to change but simply may be identifying the desire for some stability or predictability in their working environment.

Results of the Assumption Exercises (Appendix E)

Thirteen assumption exercises were distributed by email to the study participants. Participants had the option of returning the exercise with their name or anonymously. Eight exercises were returned. A detail of the responses can be seen in Appendix G.

- 1) It is a nurse's responsibility to deal with problems created by others: 7/8 respondents agreed.
- 2) Clinical competence allows one to feel good about one's nursing role: 8/8 respondents agreed.
- 3) Peer support is important: 8/8 respondents agreed..
- 4) Peer support is not always present: 7/8 respondents agreed.
- 5) An effective team is a positive motivating force :8/8 respondents agreed.
- 6) Nurses need and deserve recognition of their efforts: 8/8 respondents strongly agreed.
- 7) Patients are people to be cared for and nurtured, and not people who receive a service: 6/8 respondents agreed.
- 8) Nurses know best how to define and give patient care: 7/8 respondents agreed.
- 9) Health care providers should possess the knowledge

and authority to make decisions about the plan of care:
7/8 respondents agreed.

10) Nurses cannot control the actions of other health
care providers: 5/8 respondents agreed.

These results demonstrated that the assumptions
identified through the analysis of the data match the
assumptions held by the participants.

CHAPTER 5: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Critical thinking is essential in clinical nursing practice. There must be ongoing reflection on the assumptions that underlie one's nursing actions to determine if one's beliefs and actions remain appropriate and congruent with current health care trends.

The literature review revealed a paucity of research that investigated the critical thinking skills of practising nurses. While a number of researchers have investigated the critical thinking skills of nursing students, the methods have primarily been of a quantitative nature and the results have provided mixed results that have provided minimal direction for nursing educators. The purpose of this study was to explore the underlying assumptions that Registered Nurses, who work in acute care setting ,have about their current role and practice. The qualitative methodology included the use of the critical incident exercise, the indicators of critical thinking self assessment exercise, and the follow up assumptions exercise. The critical incident exercise and the

indicators of critical thinking self assessment exercise were based on the written work of Brookfield (1987). Brookfield's definition and ideas on critical thinking were foundational to this research.

The indicators of critical thinking self assessment exercise was given to the research participants to complete independently prior to attending the group session. This researcher developed exercise was designed to allow the self evaluation of the participants on select indicators of critical thinking as determined by Brookfield (1987).

The critical incident exercise was completed in five small group sessions. Participants were only required to participate in one of the 90-minute sessions. In the session each participant identified a negative and a positive critical incident in his/her clinical practice. The instructions for this activity were given prior to the session to give the participants an opportunity to think about their selection of a critical incident.

The critical incident technique has been used by numerous educators and researchers to identify learner's underlying assumptions (Brookfield, 1991).

The indicators of critical thinking self assessment exercise was new and had not been used before.

The indicators of critical thinking self assessment exercise indicated that the majority of the nurses responding did score themselves affirmatively on eight out of nine indicators of critical thinking. A common response was "sometimes true", indicating that the nurses recognized the importance of the behaviour but acknowledged that they did not consistently engage in those behaviours.

The critical incident exercise was effective in identifying assumptions in clinical practice. The exercise was identified by the participants as being a valuable activity in promoting the reflection and examination of these assumptions, primarily through the benefits of peer discussion and idea exchange.

Ten assumptions were derived from an analysis of the data. The assumptions were reflected back to the participants in the form of a written exercise. The ten assumptions were supported by the majority of the respondents.

Conclusions

This qualitative study had sought to address the concern that nurses need to identify and reflect on their assumptions to determine if their beliefs and actions remain appropriate and congruent with current health care trends. This study explored and addressed the following research questions.

1. What are the underlying assumptions that Registered Nurses hold about their current nursing practice? The critical incident technique exercise was effective in revealing ten assumptions about clinical nursing practice.
2. Do Registered Nurses reflect on the assumptions that influence their clinical practice?

In the group sessions the participants demonstrated the ability to identify their assumptions, but there were very few anecdotes describing the challenging of assumptions and the imagining of alternatives. This finding could have been influenced by the brevity of the sessions and the nature of the critical thinking process and the length of time that this process requires.

3. Does the participation in the identification of

critical incidents exercise promote the development of critical thinking in nursing? The participants in this study identified the value of peer sharing and having the opportunity to engage in discussions that allow for reflection and non judgemental feedback. This finding has significance for nursing educators in that it provides support for a strategy that promotes the development of critical thinking skills. It is important to note though that the exercise simply acts as a starting point or catalyst in the critical thinking process.

4. How do Registered Nurses evaluate themselves on the indicators of critical thinking self assessment exercise?

This study provided the opportunity to trial the indicators of critical thinking self assessment exercise. The exercise does appear to have the potential for promoting self assessment of critical thinking behaviours.

Recommendations

The indicators of critical thinking exercise proved to be an effective method of participant self appraisal. A recommendation for future studies would be to review and discuss the participants responses, simply collecting the exercises reduces the value that could be gained from a discussion.

The selection of a qualitative approach has proven to be valuable in the identification of assumptions in clinical practice. Further qualitative studies need to be done to explore if the assumptions identified in this study are also held by nurses in other settings. The process of analyzing and interpreting the data in this qualitative research was a definite critical thinking experience for this researcher. When one becomes immersed in the data it becomes important to take a step back and seek external feedback from peers and advisors. Many of the insights that were gained from the analysis only came after time away from the data which allowed for a period of reflection and dialogue with others. Data analysis was a lengthy and challenging experience.

It is important for educators, nurses and

researchers to acknowledge that critical thinking can be a very complex and difficult process. We should take care in attempting to promote and develop this skill by recognizing that critical thinking is a journey rather than a destination.

Where am I going I don't know

When will I get there

I ain't certain

All that I know is I am on my way

(From Paint your wagon)

References

- Arons, A. B. (1985). Critical thinking and the baccalaureate curriculum. Liberal Education 71(2), 141-178.
- Bader, M. M. (1988). Nursing care behaviours that predict patient satisfaction. Journal of Nursing Care Quality, 2(3), 11-17.
- Beeken, J. (1993). The relationship between critical thinking and self-concept in selected staff nurses practising in a variety of health care settings. Unpublished doctoral thesis, University of Wyoming
- Benner, P. (1984). From novice to expert. California: Addison-Wesley Publishing.
- Brigham, C. (1989). Critical thinking skills in nursing students progressing through a nursing curriculum. Dissertation Abstracts 50(5), 1849
- Brookfield, S. (1987). Developing critical thinkers. San Francisco: Jossey-Bass Publishers.
- Brookfield, S. (1990). Using critical incidents to explore learners assumptions. In J. Mezirow and Associates Fostering critical reflection in adulthood. San Francisco :Jossey-Bass Publishers.
- Brookfield, S. (1991). Becoming critical thinkers. Audio tape. San Francisco: Jossey-Bass Publishers.
- Brookfield, S. (1993). On impostership, cultural suicide and other dangers: How nurses learn critical thinking. Journal Of Continuing Education in Nursing. 24(5), 197-205.
- Brooks, K. (1990). The relationship between clinical decision-making skills in nursing and general critical thinking abilities of senior nursing students in four types of nursing programs. Journal of Nursing Education. 29(9), 391-399.
- Buzath, J., Lievaart, B., & Schow, E. (1992). Political action, choice or obligation. The Canadian Nurse 2, 35-36.

- Callahan, Sister M. (1992). Thinking skills: An assessment model in the 90s. Journal of Nursing Education. 31(2), 85-87.
- Candy, P.C. (1991). Self-direction for lifelong learning. San Francisco: Jossey-Bass.
- Case, B. (1994). Walking around the elephant: A critical thinking strategy for decision making. Journal of Continuing Education in Nursing. 25(3), 101-110
- Cranton, P. (1992). Working with adult learners. Toronto: Wall & Emerson Inc.
- Diekelmann, N. & Lam, S & Schuster, R. (1991) MARTIN. Madison: School of Nursing, University of Wisconsin- Madison.
- Ennis, R. (1962). A concept of critical thinking. Harvard Educational Review 32(1), 81-96.
- Ennis, R. (1985). A logical basis for measuring critical thinking skills. Educational Leadership. Oct, 44-48.
- Glass, H. Dick, J. (1992). Nursing economics in Canada. The Canadian Nurse 10, 47-48.
- Gross, Y.T. & Takazawa, E.S. , & Roe, C.L. (1987) Critical thinking and nursing education. Journal of Nursing Education 26, 317-323.
- Harbison, J. (1991). Clinical decision making in nursing. Journal of Advanced Nursing. 16, 404-40.
- Jones, S., & Brown, L. (1992). Critical thinking: Impact on nursing education. Journal of Advanced Nursing. 16, 529-533.
- Kerr, J., & MacPhail, J. (1991). Canadian nursing: issues and perspectives. Toronto: Mosby Year Book.
- Kintgen- Andrews, J. (1991). Critical thinking and nursing education: Perplexities and insights. Journal of Nursing Education 30(4), 152-157.

- Klaassens, E. (1988). Improved teaching for thinking. Nurse Educator 13(6), 15-19.
- Megivern, K, Halm, M., & Jones, G. (1992). Measuring patient satisfaction as an outcome of nursing care. Journal of Nursing Care Quality. 6(4), 9-24.
- Merriam, S. (1988). Case study research in education. San Francisco: Jossey-Bass Publishers.
- Mezirow, J. (1990). Fostering critical reflection in adulthood. San Francisco: Jossey-Bass Publishers.
- Miller, M. A. (1992). Outcome evaluation: Measuring critical thinking. Journal of Advanced Nursing 1992 17, 1401-1407.
- Norris, S. (1985). Synthesis of research on critical thinking. Educational Leadership. 5, 40-45.
- Polit, D., & Hungler, B. (1983) Nursing research: Principles and methods. (2nd ed.) Toronto: J.B. Lippincott.
- Powell, J. A. (1989). The reflective practioner in nursing. Journal of Advanced Nursing 14, 824-832.
- Prescott, P. A. (1993). Nursing: An important component of hospital survival under a reformed health care system. Nursing Economics 11(4), 192-199.
- Schank, M. J. (1990). Wanted: Nurses with critical thinking skills. Journal of Continuing Education in Nursing. 21(2), 86-89.
- Seligman, M. (1990). Learned optimism. Toronto: Pocketbooks.
- Stein, J., Su, P.Y. (1978). The random house dictionary. New York: Ballantine Books.
- Street, A. (1992) Inside nursing. Albany: State University of New York Press.

- Sullivan, E.J. (1987) Critical thinking, creativity, clinical performance, and achievement in RN students. Nurse Educator. 12(2), 12-16
- Synder, M. (1993). Critical thinking a foundation for consumer-focused care. Journal of Continuing Education in Nursing. 24(5), 206-210.
- White, N.E. (1990). Promoting critical thinking skills. Nurse Educator. 15(5), 16-19.

Appendix A
Recruitment Letter

Attention RNs!

Volunteers are needed to participate in a nursing research project that explores critical thinking in nursing. Involvement includes the completion of a questionnaire (not a test!) and participation in one ninety minute small group discussion.

Your involvement would be greatly appreciated! Please email me if you are able to be involved in one of the scheduled sessions listed below.

The sessions will be held on the following dates and times.

Friday Oct 7th : 1400-1530 Cl# 3
Monday Oct 9th : 1400-1530 Meeting room
Wednesday Oct 11th: 1400-1530 Meeting room
Thursday Oct 12th: 1400-1530 Cl #3
Friday Oct 13th: 1400-1530

Thanks for your support

Debbie Bate

APPENDIX B

Indicators of Critical Thinking Self Assessment
Exercise

(title was not placed on the distributed exercises)

Please respond to the following statements prior to attending the group session. Note: there are no wrong or right responses.

1. I have firm convictions that don't change with the circumstance.

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

2. I am able to view both sides of an argument

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

3. I have a tolerance for ambiguity

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

4. I believe that there is usually a simple answer to every problem

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

5. I seek and explore alternative ways of thinking

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

6. I question commonly held group beliefs

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

7. I like to do things the way I've always done them.

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

8. I see many possibilities for the future

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

9. I reflect on the reasons for my actions

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

10. My colleagues reflect on the reasons for their
actions

1	2	3	4	5
never	rarely	sometimes	often	always
true	true	true	true	true
of me	of me	of me	of me	of me

APPENDIX C

Critical Incident Questionnaire

These written descriptions will be for your reference only and will not be collected or read by any of the participants or this investigator.

Think back over the last six months in your work. Identify a high point in your clinical nursing practice. Briefly write down in one or two sentences a description of the incident including when and where it occurred, who was involved (roles rather than personal identities), and what particularly about the incident made it a good or positive experience for you.

The second activity involves you identifying a low point in your clinical nursing practice that occurred within the last 6 months. Briefly write down in one or two sentences a description of the incident including when and where it occurred, who was involved (roles rather than personal identities), and what particularly about the incident made it a bad or negative experience for you.



Brock University

Faculty of Education
Pre-Service

St. Catharines, Ontario
Canada L2S 3A1

Telephone (416) 688-5550 Ext. 3341
Fax (416) 685-4131

Consent Form Critical Thinking in Clinical Nursing Practice

I _____ have been asked to participate in a research study on the critical thinking skills of practising nurses.

This research is being conducted by Debbie Bate RN, BScN, an educator, at Humber Memorial Hospital. Participants will be given this consent form to sign with an explanation of the study. Questions about the project will be answered to the satisfaction of the participants.

Participation requires the completion of a questionnaire and involvement in a ninety minute group discussion, facilitated by Debbie Bate, on the subject of negative and positive critical incidents in clinical practice.

The participant may withdraw from the study at any time. A tape recorder will be used during the interview and the tape will be destroyed once the project is completed.

No names will appear on the written transcriptions, reports or published papers. Participants may have an option of seeing a copy of their own data prior to any publication of this material.

There are no risks related to participating in this study. The degree of risk is about the same as having a discussion with a peer about what one is thinking and/or feeling. Direct benefit may be experienced from having the opportunity to express personal thoughts in the presence of attentive listeners.

The participant is free not to answer any question(s) in order to protect privacy.

Debbie Bate can be reached at extension 4591 at any time if questions or concerns come up.

Appendix E

Please respond to the following statements by indicating the degree to which you agree or disagree with each of the following statements.

1. It is a nurses responsibility to deal with problems that are created by others.

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

2. Clinical competence allows one to feel good about one's nursing role.

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

3. Peer support is important

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

4. Peer support is not always present.

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

5. An effective team is a positive, motivating force

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

6. Nurses need and deserve recognition of their efforts

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

7. Patients are people to be cared for and not people who receive a service

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

8. Nurses know best how to define and give patient care

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

9. Health care providers should possess the knowledge and authority to make decisions about the plan of care

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

10. Nurses cannot control the actions of other health care providers

Strongly disagree	moderately disagree	undecided	moderately agree	strongly agree
----------------------	------------------------	-----------	---------------------	-------------------

Appendix F
Summary of the Self Assessment Exercise Results

2. I am able to view both sides of an argument.

15% (2/13) - "sometimes true"
61% (8/13) - "often true"
23% (3/13) - "always true"

3. I have a tolerance for ambiguity.

31% (4/13) - "rarely true "
54% (7/14) - "sometimes true "
15% (2/15) - "often true",
0% - "always true".

4. I believe that there is usually a simple answer to every problem.

An affirmative score indicated a negative response to the indicator.

38% (5/13) - "rarely true"
38% (5/13) - "sometimes true"
23% (3/13) - "often true".

5. I seek and explore alternate ways of thinking.

30% (4/13) - "sometimes true"
54% (7/13) - "often true"
15% (2/13) - "always true".

6. I question commonly held group beliefs.

31% (4/13) - "rarely true of me"
38% (5/13) - "sometimes true of me"
31% (4/13) - "often true of me".

7. I like to do things the way I've always done them.

An affirmative score indicated a negative response to this indicator.

72% (10/13) - "sometimes true"
23% (3/13) - "often true"

8. I see many possibilities for the future.

7% (1/13) - "rarely true of me"

38% (5/13) - "sometimes true"

38% (5/13) - "often true"

15% (2/13) - "always true"

9. I reflect on the reasons for my actions.

15% (2/13) - "rarely true"

15% (2/13) - "sometimes true"

38% (5/13) - "often true"

38% (5/13) - "always true"

10. My colleagues reflect on the reasons for their actions.

15% (2/13) - "rarely true"

61% (8/13) - "sometimes true"

15% (2/13) - "often true"

Appendix G

SUMMARY OF THE ASSUMPTION EXERCISE

1. It is a nurses responsibility to deal with problems that are created by others.

Strongly disagree 1/8
Moderately agree 6/8
Strongly agree 1/8

2. Clinical competence allows one to feel good about one's nursing role.

Moderately agree 1/8
Strongly agree 7/8

3. Peer support is important

Moderately agree 1/8
Strongly agree 7/8

4. Peer support is not always present.

Moderately disagree- 1/8
Moderately agree -5/8
Strongly agree- 2/8

5. An effective team is a positive, motivating force

Moderately agree- 1/8
Strongly agree- 7/8

6. Nurses need and deserve recognition of their efforts

Strongly agree - 8/8

7. Patients are people to be cared for and not people who receive a service

Moderately disagree- 1/8
Undecided- 1/8
Moderately agree- 1/8
Strongly agree- 5/8

8. Nurses know best how to define and give patient care

Moderately disagree- 1/8

Moderately agree- 5/8

Strongly agree- 2/8

9. Health care providers should possess the knowledge and authority to make decisions about the plan of care

Undecided- 1/8

Moderately agree- 3/8

Strongly agree- 4/8

10. Nurses cannot control the actions of other health care providers

Moderately disagree- 1/8

Undecided -2/8

Moderately agree- 5/8